Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RICHARD B LAWRENCE MD
P O BOX 741865
DALLAS TX 75374

Respondent Name

ARCH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3073-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAM; CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS; THE CURRENT RULES ALLOW REIMBURSEMENT; AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED; THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $1,501.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20, 2011	99456-WP-W5 99456-RE-W8 95851 x 2 units	$500.00 $500.00 $51.28	$500.00 $500.00 $0.00
TOTAL		$1,051.28	$1,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers'

compensation specific codes, services and programs provided on or after March 1, 2008.

3. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §130.6 set out procedures for Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings.
5. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041 provides general provision for Designated Doctor Examinations and carrier responsibilities for payment of such services.
6. Copies of the explanation of benefits were not submitted by either party for review. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.

Issues

1. Is the dispute eligible for review under 28 Texas Administrative Code §134.307?
2. Were the services in dispute appropriately billed?
3. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is CPT code 95851 included in the MMI/IR examination?
5. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. 28 Texas Administrative Code §134.307(c)(2)(B) states, "Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division…The provider shall complete the required sections of the request in the form and manner prescribed by the division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include…a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute, or if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation the Division finds that the requestor did submit convincing evidence to support carrier receipt of "Request for Reconsideration" in accordance with Rule 133.307(e)(2)(B). The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.
2. The requestor billed the amount of $650.00 for CPT code 99456-WP-W5 with 1 (one) unit in Box 24G of the CMS-1500 for a Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The requestor also billed the amount of $500.00 for CPT code 99456-RE-W8 with 1 (one) unit in Box 24G of the CMS-1500 for a Return to Work (RTW) examination. Additionally, the requestor billed the amount of $51.28 for range of motion testing.
3. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the submitted documentation supports the impairment rating of the lumbar spine (spine) with the Diagnosis Related Estimate (DRE), Category II method per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the spine is per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and the Maximum Allowable Reimbursement (MAR) for the Impairment Rating is $300.00. The Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-WP-W5 is $650.00. Additionally, the requestor billed $500.00 for CPT 99456-RE-W8, for an examination to determine the ability of the employee to return to work. Review of the submitted documentation supports that the examination to determine the ability of the employee to return to work was performed. Per 28 Texas Administrative Code §134.204(i)(1)(E) and (k), the Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-RE-W8 is $500.00. The combined MAR for the MMI/IR and RTW examination is $1,150.00. The requestor's *Table of Disputed Services* lists the total amount in dispute as $1,000.00 for CPT code 99456-WP-W5 and 99456-RE-W8. This amount is recommended.
4. The provider also billed the amount of $51.28 for 2 units of Range of Motion (ROM) testing for the MMI/IR examination. There was no reimbursement for the CPT code by the respondent. 28 Texas Administrative Code §134.204(j) states in pertinent part, Reimbursement for the MMI/IR exam includes the following components: The medical examination; consultation with injured worker; Review of medical records and films; Reports (DWC Form-069), including the initial narrative report as well as any subsequent reports in response to the need for clarification, explanation, or reconsideration; Calculations, tables, figures, and worksheets; and Tests used to assign an IR, as outlined in the AMA's *Guides to the Evaluation of Permanent Impairment* (AMA Guides) [as stated in the Act and Chapter

130 rules]. Therefore, in accordance with 28 Texas Administrative Code §134.204(j), CPT Code 95851, Range of Motion (ROM) testing, is included in the reimbursement for the MMI/IR exam and is not separately payable. No additional amount for CPT code 95851 can be recommended.

5. The respondent has previously reimbursed the amount of $0.00 for the disputed services. Therefore, the requestor is due a recommended reimbursement in the amount of $1,000.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,000.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,000.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 10, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.